



# Division of Diabetes Treatment and Prevention

## Making the Connection: Improving Diabetes Self-Management Education and Support

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Brenda Broussard:

Thank you Jan. Hello, I'm Brenda Broussard. I'm a Registered Dietitian, Certified Diabetes Educator, and Healthcare Consultant in Albuquerque, New Mexico. I've been working in Indian health and diabetes at the tribal, area, and national level for over 30 years. I'm the daughter of a mother who died of the complications of Type 2 diabetes, and the sister of siblings with diabetes. Cecilia?

Cecilia Butler:

Thank you, Brenda. Hello, my name is Cecilia Butler. I also am a Registered Dietitian, Certified Diabetes Educator. I've been working in Santa Fe Indian Hospital and for the Service Unit for about 16 years. I have to say that while I've been here, I've worn many hats, but I have to tell you that probably the most challenging and rewarding hat that I wear is as a diabetes educator. Thanks, Brenda.

Brenda Broussard:

Thanks, Cecilia. And we'd like to thank Dr. Ann Bullock for suggesting today's topic, "Improving Diabetes Self-Management Education and Support". Together we will share some ideas, thoughts, strategies, evidence, and a case study that makes that connection and suggests some actions you can take in your practice. As Jan said, Cecilia and I are seasoned educators and we know that many of you on the call are also experienced diabetes educators and clinicians.

Now, in getting ready for this presentation, I reviewed the diabetes education research literature and I was surprised to learn there isn't much new in the past 10 years. Much of the research was published in the 1990s and early 2000s. Yes, there has been some since, but the bulk of the work was done a while ago. Now, we'll share today some of Dr. Sharon Brown's work in South Texas over the past 20 years. It's some thought-provoking interventions with relevance to our Native American communities, to SDPI programs, and of course to educators.

Now, when I think of diabetes self-management education and support, I think it's an art as well as a science, and in fact that's the title of a book from AADE. Now, my practice has changed over the years because of what I've learned from patients and from watching, listening, and learning from other educators. Think about it. Has that been your experience, too?

Cecilia and I will share some practical tips and invite you to share your expertise by participating through the chat box and some poll questions that we have during the presentation.

Now, this is a photo of Barbara Mora and her husband, Bob, on the cover of her book and audio CD, "Using Our Wit and Wisdom to Live Well with Diabetes". It's available from the IHS Division of Diabetes. I met them in Albuquerque a few years ago at the Indian Health Advances Course. Barbara shows such courage to come forth and talk so honestly about what it's like to live with the fear of diabetes, and then be diagnosed with it.



She recounts in her book, "I'll always remember the day in the clinic when the doctor said, 'You have diabetes.' I thought of my mother who died from diabetes complications. Then I thought, 'I will need all sorts of help. I will need to depend on people. I no longer will be able to take care of the people that I love,' and I began to cry. The doctor closed the door and let me cry. He told me my diabetes did not have to be like my mother's or anyone else's. I could create my own life with diabetes. I could decide how to live well with diabetes. I could choose.' Barbara and her doctor connected. There was feeling, trust, and empathy.

Now, I'd like you to remember a recent visit with a healthcare provider. On a scale of one to three, with one being very satisfied, two being satisfied, and three not satisfied, did you feel there was a connection between you and your provider? When you met with the provider, were you greeted and welcomed? I see some numbers coming in. Okay, it looks like about half of you were satisfied. That's pretty good. Only 14% were not satisfied, and a little bit over a third were very satisfied. Well, that's good. That's what we would hope for.

Let's see the next one. On a scale of one to three, again, did your provider ask about you and your concerns? So again, on a scale of one to three. As you can see, it's looking similar to what the first question was. A little bit over a half of you were satisfied, a little over a third were very satisfied. The final poll question. On a scale of one to three, did the provider listen to you and was attentive to you? We're seeing more... well, it's going back and forth. Okay. Again, we're seeing about the same results, about half of you are satisfied, a little bit over a third were very satisfied. Thanks for participating in the polls.

I'm going to briefly share the what, who and how of diabetes self-management education and support, or DSMES, that's a mouthful, isn't it? Then Cecilia is going to present a case study from her practice and ask you how you would interact with the patient. She's also going to share some resources with you and ask you to take action and identify one change you can make in your practice.

So what is DSMES? The National Standards define diabetes self-management education and support as the ongoing process of facilitating the knowledge, skill, and ability necessary for pre-diabetes and diabetes self-care. The overall objective are to support informed decision-making, self-care behaviors, problem solving, and active collaboration with the healthcare team, and to improve clinical outcomes, health status and quality of life. Both the National Standards and the Indian Health Diabetes Best Practice, which are referenced on the slide, emphasize the importance of ongoing support for people with diabetes.

Behavior change is the unique outcome measurement for DSMES. Many of you are familiar with the AADE 7 Self-Care Behaviors for educators and clinicians to help individuals with diabetes achieve glycemic, blood pressure, and lipids goals. Now, in the July-August issue of the Diabetes Educator is an article by doctors Sharon Brown and Haynes. They share some lessons learned from their 20-year research program testing DSME interventions, culturally tailored for Mexican-Americans living in a community on the Texas-Mexico border. As I was reading that article, I noted several parallels to our work in Native American communities, in some clinical as well as community SDPI programs.

I'm going to just briefly summarize their four lessons. The first one, lesson one, the dosage effect. I like that. More intervention attendance resulted in greater improvements in A1C. The intervention effects diminished when contact with educators ended, suggesting a need for re-inoculation. The second lesson, the impact of culture, the importance of family and involving a family member or close friend to attend the intervention sessions as a supporter for the participant with diabetes. I serve as a reviewer for many of the continuation grants, and I see this as something that many of you are doing, involving the whole community, involving the family.

The third lesson that Dr. Brown found, the importance of focus groups. Now, community members advised the researchers not to focus efforts on weight loss, but instead focus on diabetes self-care. What emerged from their focus group interviews was a strong preference by the participants for having a healthcare professional, the nurses, the dietitians, providing the educational portion of the intervention, and having the promotoras or the community health workers providing biweekly support groups. I found that very interesting.

Lesson four, motivators of behavioral health. That is, including participants' concerns for their family's health and their desire to be role models for their children.

Now, again, here's a photo of Barbara Mora with diabetes educator, Pat Odiorne, a registered dietitian and manager of the SDPI program for the Confederated Tribe of the Chehalis Reservation in Washington State. Take a look at the picture. How would you describe the interaction here? Do you see a connection between the two at the visit? Look who's doing some talking. Self-management education and support is a partnership. It's about people coming together. The person with diabetes who's an expert in his or her life, who brings their expertise, strengths, challenges, and goals to the partnership and knows what they're able to do with all the competing demands in life, often with family members at the visit. And the clinician educator who has expertise in diabetes treatment and prevention.

The Indian Health Diabetes Best Practice and the National Standards for DSMES emphasize that the person with diabetes is at the center of the entire diabetes education and support process. It's the individuals with diabetes who do the hard work of managing their condition day in and day out. Our job, the clinician and educator's role first and foremost is to make that work easier. We do this by sharing knowledge and skills in diabetes prevention and or treatment, tools and resources and providing support and good listening.

There's this great quote by John Maxwell. "People don't care what you know until they know that you care." So how do we provide excellent DSMES? Keep in mind just as I did at the beginning of my talk, how you like to be treated when you see a healthcare provider.

Now, a lot of people have asked, okay, what's the best way to do it, especially new folks coming into diabetes education. Well, there are many approaches. There's no one best model. I'm just going to touch briefly on two models. The first one, a strengths-based approach, where the clinician educator understands that people come to the visit with their own life experiences, and recognizes that everyone has unique strengths and helps to build on their strengths. I liken it to the glass half full instead of looking at it as half empty.

Another model that many of you are familiar with is the patient-centered medical home model, used by the Indian Health Improving Patient Care programs or IPC programs. I'm curious to see on the call if any of you are involved with that in diabetes education, maybe quality assurance, and if you share some of that experience.

We also provide patients with specific education, behavioral skills and strategies needed to address the issues that they have self-identified as of concern to them. We negotiate and agree on a plan discussed during the visit and you'll see that process explained in the case study that Cecilia is going to present. We provide support and encourage the individual to seek support from family and friends, and other providers as needed. I love this, "I kept coming for the love." It's the title of an article by Dr. Raffel and colleagues at the University of Chicago, looking at factors contributing to retention in a diabetes education program for urban African-Americans. Quotes from the participant such as, "It was the warmth and the understanding of the staff, the educators, the doctors, all of them, greeting us, asking us how we're doing, the love. It kept me coming back for more." I think you'll agree. It's more than just the science of diabetes education. Now, let's hear from Cecilia.

Cecilia Butler:

Thanks, Brenda. So we're going to get started on the case study, and one of the things, first things that I wanted to do is I wanted to welcome all of you to Santa Fe Indian Hospital, to invite you to come in and see our newly renovated outpatient clinic. This is our new outpatient waiting area. The glass door to your right is a patient entrance to the new clinic. Down the center are three semi-private patient registration stations, and at the end of the hallway to your left is a door that leads to my office and the place where I see patients.

When a patient checks in for their appointment, I receive a notification that lets me know if the patient is in the waiting area. Then, I walk to the waiting area, call the patient by name and escort them into the clinic to get screened before taking them into my office. It's during this time that I introduce myself and engage the patient in conversation that is usually not related to their appointment visit. I find this helpful as an icebreaker, and usually, the patient is more at ease when they get into my office. This is where I met Nancy three months ago after her primary care provider referred her for diabetes education.

But before I begin, before I introduce you to Nancy, I would like to begin this case study by sharing some of her medical background that I reviewed before our first visit. Nancy is a 62-year-old female with an 11-year history of Type 2 diabetes. She also has hypertension, dyslipidemia, she's having early signs of retinopathy, and has a BMI of 30. Her most recent labs, that were done shortly before our first visit in May show an A1C of 11.3%. That's followed by an A1C of 10.4 in February of this year and an A1C of 12.4 in September of 2013. Clearly, there is a trend of uncontrolled diabetes in the past year. In fact, during the review of labs, I found that her A1C has been at 9% or higher since she was diagnosed with diabetes in 2003. On the positive side, her lipids and blood pressure are controlled.

Her medications includes taking glycoside 10 milligrams b.i.d., metformin 1000 mg b.i.d. She's also taking a statin, lisinopril, and an aspirin. Another interesting tidbit is that during the review of her medications, I also noticed that Nancy has been on the same diabetes medications and dosages for the past five years.

When I met Nancy during our first visit, I had a good picture of her medical background as I have just shared with you, but I had no idea who she was and what her expectations were after visiting me. So I asked her to tell me a little about herself.

Now, let's meet Nancy. She's a single parent of four children with two who are still living at home because they are unemployed. She has a full-time job working the day shift at a local gas station convenience store. She reports getting lots of exercise because she's moving all the time and attributes this to a weight loss of 12 pounds in the past seven months. She also reports not being able to remember when she last monitored her blood sugar but recalls that she stopped because seeing her blood sugar over 200 all the time added more stress to her life. She also reports taking all her medications in the morning before she goes to work, or will often take them in the evening before she goes to bed. She did also mention that sometimes she forgets to take them altogether. To my surprise, Nancy told me that she had never met with a diabetes educator or a dietitian, but has been trying to make some diet changes.

One of the diet changes that she has made is buying gluten-free bread and cereals. She read that the gluten-free foods are healthier, but the problem is cost. These foods are more expensive and the family doesn't care for them. She also reports that she skips breakfast because she doesn't have time and comments that buying the gluten-free cereal was probably not the best choice.

In reviewing her 24-hour recall, her morning begins usually around six o'clock in the morning and she drinks two mugs of regular coffee, which I estimated to be about six cups with a powdered creamer,

Splenda, and a granola bar. Lunch is usually between 10 o'clock in the morning and 1 p.m. and she usually has a turkey and cheese sandwich with lettuce and tomatoes, often adding jalapeño or mustard. She also has a small bag of baked chips and bottled water that she purchases there at the convenience store.

She has an afternoon snack before her shift is done, about 4:30 p.m., and usually chooses a bag of peanuts or granola bar and water. For dinner, she had a bowl of ground beef mixed with potatoes and corn. I estimated that bowl to be about two handfuls, which is about a cup. She also had about half of a tortilla and water. She says that her daughter who is living at home helps to prepare dinner, and that they seldom eat out because money is tight. Overall, her reported intake from what I could see was not excessive in calories but adding more vegetables especially to dinner may help reduce her carb intake.

In listening to Nancy, I was able to learn a great deal about her, but it wasn't until I asked her, "How can I help you?" that I was able to understand what she wanted to learn. Her response was, "My doctor told me that my A1C is high and I need to lower it but I'm not sure where it supposed to be." She said, "I know when I was checking my blood sugars, they were high all the time. I want to know how I can lower them to where they need to be." She continued by expressing her desires to eat healthier foods, but after paying bills, buying gas for her truck and supporting her two children at home, money was an issue.

After sharing this, she became emotional and said that her bigger concern is her eyesight. She said, "I'm having a hard time with my eyes and don't want to lose my sight. That's why I came to see the doctor." Now, I have to confess to all of you that even after all these years as a diabetes educator, I still get that impulse to fix it, to take charge, to tell the patients what I think is best for them, especially when patients are emotional. That is probably one emotion that triggers most of this for me all the time.

So I ask all of you, do you struggle with that? Do you struggle and share in this also? Now, I have to remember and constantly remind myself, and Brenda mentioned it earlier, that the National Standards emphasize that the person with diabetes is at the center of the entire diabetes education and support process. I know you already heard this but I think it bears repeating that it is the individuals with diabetes who do the hard work of managing their condition day in and day out, and the educator's role first and foremost is to make that work easier.

Nancy has much to contend with. Here are her issues. In the clinical, we know she has uncontrolled diabetes, she has lost a lot of weight. It could be because she is active but maybe some of that weight is also related to her uncontrolled diabetes. Another thing that we know is that there hasn't been really a change in her oral diabetes medications for quite some time. As far as behavior, she is not monitoring blood sugars. She is not taking her diabetes medicines as prescribed and there are numerous stressors. One of them that she identified is her finances and the other is her poor eyesight.

So in light of this, the education that I provided Nancy was not only based on the issues that I just discussed but it's also based on her requests and concerns. So I discussed A1C goals. An A1C goal and how it correlates to blood sugar, to her blood sugar goals. Secondly, I discussed the benefits of glucose monitoring and described it as her new best friend. Why? Because a best friend has the best interest at heart.

I issued her, I gave her a new glucose meter and I watched her demonstrate to make sure she knew how to use it. I explained that gluten is a protein and the gluten-free foods are beneficial for persons who cannot tolerate this protein. I also discussed how to eat healthy on a low budget and the benefit of adding seasonal vegetables to meals to reduce her carb intake. I also explained how diabetes medications work and the importance of taking them as prescribed.

The next step was to help Nancy with goal setting. I find that the key component in helping an individual set a goal is in listening to her concerns or requests. In doing this, I can usually help turn that concern into a goal. If you recall, Nancy has already identified that she wants to lower her A1C to prevent diabetes-related complications to her eyes.

So how is this done? Well, first, we want to look at the big picture. The big picture is pretty much the education that I have provided and what needs to be done. The second step, Nancy has already said that her goal is to lower A1C, and after the education, she actually said, "I think I probably want to stick to a goal of eight." I suggested the seven. She said, "You know what? I think I'm going to stick with the eight because then, it's easier to get to, and then I'll go to a seven." Then by coaching, I helped her break down this goal into the smaller steps to reach this goal. The smaller steps are, one, I suggested that monitoring blood sugars would probably help in guiding her to get that goal of an eight for an A1C, and she agreed. I also suggested that taking her diabetes medications as prescribed might also help in bringing those blood sugars down and reaching her goal, and she agreed.

Then, I asked her, "Well, you know what, Nancy? What can you do about your diet? It sounds like maybe you need a little bit of vegetables to reduce those carbs intake. What can you do?" She said, "You know what? I think I can probably start by adding one vegetable to my meal." She identified that meal to be dinner.

So in the process of planning, of setting the goals and negotiating, this is the plan that Nancy and I came up with. The plan is that she's going to check her blood sugars twice a day and I gave her her fasting goal and her two-hour postprandial after dinner goal. I suggested that maybe I would get her a pillbox. I had the pharmacy give her a pillbox as a reminder to take her medications, her diabetes medications 30 minutes before lunch and dinner because as you recall, she was taking them all at once and I wanted to see if perhaps that might help to get her blood sugars down. Then we of course added that she was going to include a vegetable for dinner. We scheduled the follow-up for two weeks.

One of the things that I suggested on the cuff for Nancy, I said, "You know what Nancy if you're still inclined, I'm going to suggest that you keep a food journal. This is my goal for you, that you keep a food journal, whatever you can of any meal as many days as you want, because this would be helpful as I provide more education for you on meal planning, and it'll also be very helpful in case we need to make a medication adjustment or a change as needed." She agreed.

On the follow-up visit which is the second visit, Nancy reported that she was taking her diabetes medications before meals. She actually missed taking them or forgot to take them on two occasions. She's checking her blood sugars on most days and these are the results of her fasting blood sugars which range about 189 to about 215. Her two-hour postprandials after dinner are still ranging about 195 to 283.

Her food journal, I praised her repeatedly because she actually kept a food journal and she had four days of entries. That food journal pretty much showed that of course, she stopped the gluten bread, so she changed it to whole-wheat. She was adding a salad to dinner, but breakfast and lunch pretty much, were still the same.

However, as I praised her for her hard work, she became very emotional. When I asked her what was wrong, she said, "I am very concerned about my blood sugars. They are still very high and this worries me." She expressed that the worry for her eyesight has now intensified because she can actually see the blood sugars and she doesn't know if what we're doing is actually working.

Based on what Nancy reported to me, and also on the fact that she has an 11-year history of diabetes, she's been taking those oral medications with little results, she's highly motivated to reduce her A1C as quickly as possible, I discussed the benefits of using insulin and discontinuing glipizide and asked

Nancy if she would consider starting a small dose of insulin. Surprisingly enough, after a few questions from her as to how, when, where, how often, and all the questions that are pretty familiar with someone who's going to start insulin, after I addressed them, she agreed. What I did then is that I consulted her primary care provider who was on site, and he ordered the insulin and stopped the glipizide.

So we started her on 20 units of basal at bedtime and his instructions were to add two units every three days until she reached her blood sugar goal of 70 to about 130.

The physician opted to add two units rather than three just to get her going, and left room for discussion at another time. One of the other things that I did is that I provided Nancy with instruction on how to take the insulin, and I also helped her with a meal plan for her breakfast. My concern of course is to prevent hypoglycemia and so she agreed to start packing a lunch for breakfast. What I told Nancy is that I would be calling her to monitor her progress and that we would follow up in three more weeks.

Right shortly after the visit, about six days later, I called Nancy and at that time, she reported she was still taking the basal insulin and she was taking it at 20 units at bed time. She reported then that her fasting blood sugars were 152, or ranging 152 to about 175, and that her two-hour postprandials, after dinner, were also ranging about 167 to about 128.

At that time, she had not added two units to her regiment as we had discussed, and so I encouraged her to add two units every three days to meet her fasting target. I also asked her, "How are you doing with breakfast?" and she says, "I'm eating breakfast. That was the easy part." So I praised her again and up to this point, Nancy's demeanor in her voice sounded a lot more calm and more confident.

I called her back 11 days later and found out that she had already increased her insulin to 26 units at bed time, and now her fasting range is about 121 to about 138, and her two-hour postprandials after dinner were ranging 143 to 171. She continued to eat breakfast. She denied hypoglycemia, and she said she was doing great.

I reminded her of her follow-up visit, and she was right on time for her third visit. When she came in, she reported that she had had a couple of blood sugars since I had last talked to her that were greater than 180 but the rest were pretty much at goal.

On this visit though, I wanted to focus on her behavior changes. That's what I wanted to share with you on this third visit. Nancy continued to keep her food journal, and not only was she tracking all her meals but she was also tracking her blood sugar values right next to her meals.

She is eating breakfast and often now is packing a lunch and excited because she says that she's saving money. She's taking her medications, her insulin including her medication, and using a pillbox. Overall, she's feeling stronger and she's feeling more confident. She also reports that her family is also making the diet changes. I'll tell you, I'm looking forward to her next A1C results, which is going to be becoming up at the end of the month.

In summary, I can attest that Nancy valued the education and honestly, did all the hard work, and I am so glad for those national standards and for the reminder that you know what-- it's not up to me, it's up to Nancy. She took ownership of her self-care. She felt safe, she felt cared for, and she felt listened to. I think she also gained a lot of trust for the health system, and that, I'm being very subjective with that. The reason I say that is because she was just more, she just demonstrated that trust in wanting to come and keeping appointments. She also gained confidence by the education and the support.

Now, I'd like to turn your attention to some of the resources that are available to you and they're specific for American-Indians and Alaska Natives, and these are from the Division of Diabetes, and they include the DSMES Best Practices. It also includes using the "Wit and Wisdom to Live Well with

Diabetes" as Brenda introduced earlier. You can see here that there are two pictures, and one of them is Living a Balanced Life with Diabetes toolkit which addresses the psychosocial issues, and My Native Plate, there are many more resources on their website, and another great resource from the National Diabetes Education Program and the National Standards for DSME.

Now, pretty much, Brenda brought you through the what, who and how. I gave you a preview or review of my long-winded case study. I also have given you some resources that are very helpful, and now it's time for action, one change that you can make in your practice. I think most of you are already taking action with your clients and I have to acknowledge that I know on this webinar there are many of you who are very seasoned and have a tremendous amount of expertise, much more than I probably have because you're probably have done it longer. Nonetheless, we all have our style, we all have our technique. I'll tell you, there is no one way to do it, and I would love at some point to hear your comments or for you to share what you've done as you've listened to my case study. What would you have done differently? How would you have approached it? Anything, suggestions that you can offer, is valuable for the rest of us. I'd also like you to think about one change that you can make in your practice to improve DSMEs for your clients.

And here's a poll question. What other DSME topics would you suggest for a future Advancements webinar? I would invite all of you as the screens have come up to present any ideas that you might have as far as any future webinars that you would like to hear especially surrounding the subject.

I would like to throw one out, first of all and that's pretty much as I mentioned before, that there are so many of you out there who have so many different expertise. I would like to hear from a nurse and how a nurse approaches a case study like I do. I think that when I met Nancy, one of the things she of course knew about me was that I was a registered dietitian and sometimes for many of my patients, that seems to resonate, the fact that I'm a dietitian, and being a diabetes educator is second, and so most patients will always bombard me with food issues. I'd like to know how patients would approach a nurse educator, how they would approach a pharmacy CDE, or another discipline who is also a diabetes educator, and these are some of the webinars that I would like to hear. I think there are some suggestions already coming up. Brenda, do you want to go ahead and --

Brenda Broussard:

Sure, there are. These are great.

Cecilia Butler:

Yeah.

Brenda Broussard:

For example, a couple on billing. One that caught my attention, related to psychosocial motivational interviewing, but this is a tough one, anger related to the diagnosis of diabetes. Often, in the clinic, we're the ones who have the luxury if you will of a little more time, and for patients to express their emotions. And Cecilia, I bet in your initial visit with Nancy, it wasn't just a 15 or 20-minute visit.

Cecilia Butler:

My visits, even follow-ups, pretty much, I allow patients at least an hour. There have been many times, if I do have the time that I will just even let a patient just talk as much as they need to, and I've been known to be with a patient for an hour and 15, up to two hours at a time. But again, I usually let the patient dictate that to me, but yes, I give them plenty of time to express what they want to know.

Brenda Broussard:

Thanks and I'm seeing some others. For example, pain and nutrition issues, like what do you do about, well especially like neuropathy, other tracking goals, shared decision-making, cultural awareness, moving cost barriers.

Earlier today, Dr. Donnie Lee, the Portland Area Diabetes Consultant sent us a kind of an advanced copy or the headlines of an article that's coming out in the Lancet or it's just appeared in the Lancet that says, "Around the world, two out of five people will develop diabetes." As I read it, I went, oh, okay, we already passed that with Native American communities. The issue is we simply don't have enough diabetes educators. I mean, access is a real big issue. So Cecilia, I know that you presented one of the kind of like better scenarios and we had talked about that just to get those ideas across, but what do you do when you have just a big backlog of clients who either are newly diagnosed or they have long standing diabetes out of balance?

Cecilia Butler:

I approach those folks like I would anyone else. Often times, what complicates it is the fact that here where I am, as probably is the same for a lot of the folks out there, is that transportation is a big issue. Some of our patients live up to 60 miles away and the transportation is difficult. So setting appointments back-to-back or follow-up often times makes it a little bit more complicated. I'll tell you what, I think as part of that answer is that often times, I have also found out and I'm looking at reading level-appropriate materials that often times, we don't take the time to address the fact or to evaluate whether our patients have literacy problems, and those literacy problems really are just understanding the medical language. So that sometimes can become a barrier in managing some of these patients. I think we all have to be sensitive and try to really downsize our information as much as possible.

Brenda Broussard:

I've seen some great suggestions coming in over the chat line. For example, using EHR tools like goal setting and tracking on the psychosocial part, having support groups, talking circles. This is a great one from California saying, "Thank you Cecilia for your case study. Did you go back to the providers and ask why they didn't advance her meds over the 10 years when Nancy clearly was not in control?" I don't know how often she would come in to clinic, but that's a touchy one.

Cecilia Butler:

Well, and you know what? In Nancy's situation, she has 11 years' history of diabetes, but Nancy fell off. She was lost to follow-up quite a long time. These are things that I didn't mention in the case study because of the time issue, but she did mention that there were times when she was just so discouraged that she just didn't come in to see the doctor. This is one thing which reminds me. This is one thing that I constantly remind my patients, is that, you know what, if I had toothache, it hurts so bad that I would probably go to the dentist. And I pose that question to them. If you had a toothache you'd go to the dentist, and most of the time, they said, "Oh yeah, I had a toothache," or they can relate to that. I said, the key thing with diabetes is that you don't feel any pain, and most of the time, you can go about your day because you build that tolerance. Most of the time, you can go about your day and you feel like you're okay.

So that was another issue that I discussed with Nancy, was the fact that you know what, she's just so into all these stresses, into her life that half of the time she thought, "I'm really doing okay." It wasn't part of denial, I think that's just part of the way that this disease process continued.

Brenda Broussard:

Thanks Cecilia. I'm seeing another comment. Somebody is wondering about an algorithm to taper treatment on the growing number of patients seeking gastric weight loss surgery, and that gives us an opportunity to plug for the next Indian Health Diabetes Advancements, it's actually going to be on that topic with a nutritionist delivering that presentation. I'm sure Jan at the end, when she wraps up, will be telling us a little bit more about that.

Cecilia Butler:

You know what, one of the things that I see here is insulin pump therapy. I think for so many years especially with the federal facilities that we're on a formulary and it was very difficult to even think about insulin pump therapy, but now with the Affordable Care Act, where we're seeing a lot more patients getting health insurance, this is something that even some of the doctors have presented to me and that is, "Do you think so and so would benefit from an insulin pump?" So I think that that would be something that would be great to address also because I think we're going to be able to see it a little bit more.

Brenda Broussard:

I know that you addressed in your case study limited funds, limited food access for Nancy, but kind of on a bigger scale, I mean, with what some of our urban as well as rural clients are facing, I think there's an exciting project happening here on one of the pueblos. Cecilia, you probably know the name of the pueblo where they have a mobile, it's almost like a semi-truck that goes to the community. There was a grant where people can buy fresh fruits and vegetables, and I guess other perishable foods at a reasonable price.

Cecilia Butler:

That's correct, and that food truck is over at Kewa which is Santo Domingo Pueblo, near Santa Fe.

Brenda Broussard:

I think that was some action taken as well with SDPI.

Cecilia Butler:

That's correct.

Brenda Broussard:

And of course, a whole lot of work by the healthcare providers and tribal leaders and others. I'm also seeing documenting case management visits. Well I'd refer you to many more of, maybe inviting in one of our case managers. I know that there are several at Phoenix Indian Medical Center, because that's pretty much their SDPI program. But then there are also case managers for all of the competitive Healthy Heart and Diabetes Prevention Programs. I understand they're going to be coming out with a toolkit pretty soon. That will help us with basically learning some ideas over the past few years from these programs.

Jan Frederick:

Brenda and Cecilia, we want to thank you again. Dr. Bullock, do you have any closing remarks?

Ann Bullock:

Thanks Jan, and of course thanks very much to Brenda and Cecilia for doing a great job in bringing this up, and as we've seen in this last hour, so much of it is about building relationship with our patients and clients, and giving them a place to not only learn about diabetes, but perhaps, some of the emotions and express some of their frustrations not just with diabetes but with many of the challenges happening in their lives. It's so important that they know that we care about them as people and not just as a billable visit or other things that sometimes it seems like healthcare has become.

So I want to thank them, I want to thank everyone who has joined us today. Lots of great suggestions for future sessions, and it sounds like this is a topic you all want to talk about some more, and that's great. We're happy to schedule those. So thank you everyone for all the work you do for our American, Indian and Alaska Native patients and clients across the country. Thanks for joining Advancements this month and we hope you'll come back next month.